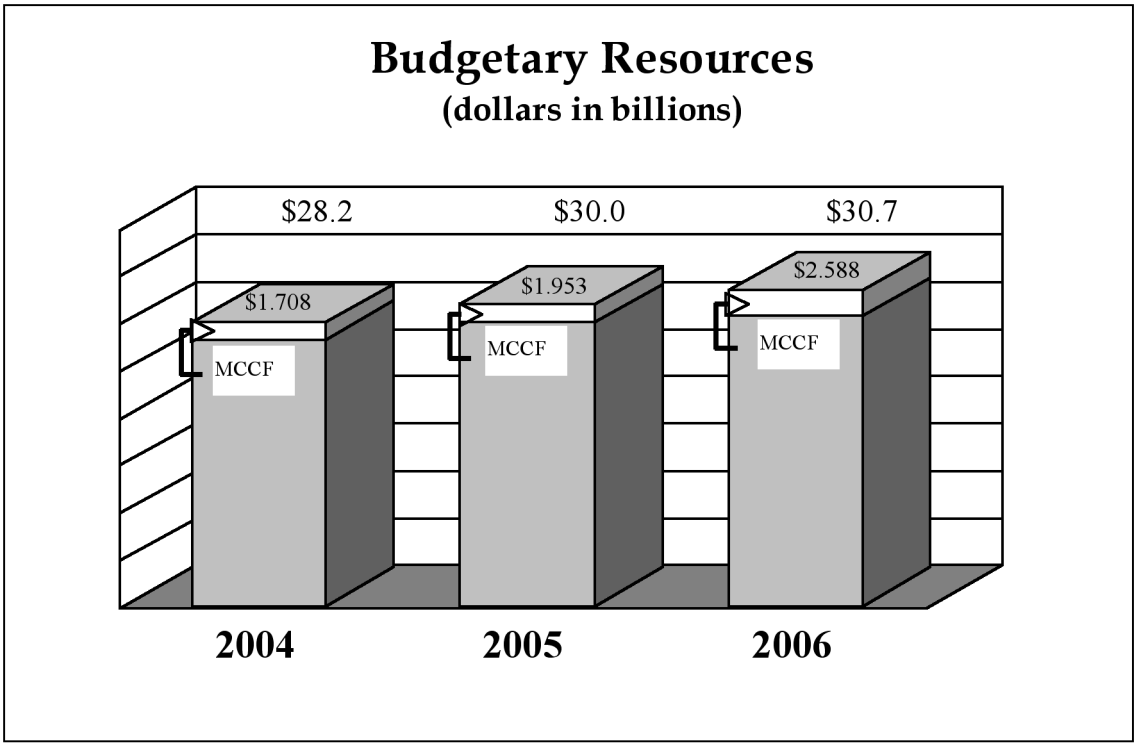
Medical Care Business Line

The Medical Care Business Line appropriation provides the resources to operate a comprehensive and integrated health care system that supports enrolled veterans; a national academic education and training program to enhance veterans' quality of care; administrative support for facilities; and capital investments necessary to ensure that the infrastructure is adequate to support the delivery of quality health care. The mission of the veterans' health care system is to serve the needs of America's veterans. Enrolled veterans receive the needed specialized and primary medical care and related social support services. To accomplish this mission, the Veterans Health Administration (VHA) is a comprehensive, integrated health care system that provides excellence in health care value; excellence in service as defined by its customers; excellence in education and research; and excellence in timely and effective contingency medical support in the event of national emergency or natural disaster.



The 2006 President's budget includes the Medical Care Business Line with budgetary resources of $30.7 billion, an increase of $752.2 million, which represents a 2.5 percent increase over the 2005 estimate. The request reflects an offset of $1.7 billion in appropriation for a comprehensive set of legislative, regulatory, and management proposals that will continue to concentrate VA's health care resources to meet the needs of our highest priority core veterans - those with service-connected conditions, those with lower incomes, and veterans with special health care needs. The construction component for the Capital Asset Realignment for Enhanced Services (CARES) projects is $699.8 million, an increase of $105.7 million in direct appropriation over the 2005 estimate. The overall business line construction program has a net increase of $17.2 million due to the one-year moratorium of funding for grants for State extended care, a reduction of $104.3 million, as VA begins a system-wide study of its long-term care services. It also reflects Medical Care Collection Funds (MCCF) of $2.6 billion, an increase of $635 million. Of the $635 million, $424 million is for a proposed $250 annual enrollment fee and an increase in pharmacy co-payments, and $211 million is for increased workload and other legislative proposals. The components of the Medical Care Business Line are reflected in the following table.

Medical Care Business Line Budget Authority - Restructured
(dollars in thousands)

	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)	Percent Change
Appropriation					
Medical services	$18,453,304 1/	$19,764,135	$19,789,141	+$25,006	0.1%
Appn. fr. prop. legisl. fees	0	0	423,996	+423,996	
Subtotal medical services	18,453,304	19,764,135	20,213,137	+449,002	2.3%
MCCF collections	1,708,026	1,953,020	2,164,004	+210,984	10.8%
Subtotal medical services	20,161,330	21,717,155	22,377,141	+659,986	3.0%
Medical administration	4,026,636	4,377,080	4,439,124	+62,044	1.4%
Medical facilities	3,083,922	3,175,744	3,188,669	+12,925	0.4%
Construction	919,815	682,559	699,800	+17,241	2.5%
Subtotal medical facilities	4,003,737	3,858,303	3,888,469	+30,166	0.8%
DoD VA HCSIF 2/	30,000	0	0	+0	
Total BA before transfers	**28,221,703**	**29,952,538**	**30,704,734**	**+752,196**	**2.5%**
Hurricane supplemental	0	122,775	0	-122,775	-100.0%
Transfers	0	-109,500	0	+109,500	-100.0%
Total budget authority	**$28,221,703**	**$29,965,813**	**$30,704,734**	**+$738,921**	**2.5%**
Obligations	**$28,379,205**	**$30,450,625**	**$31,425,817**	**+$975,192**	**3.2%**
FTE	**190,744**	**194,011**	**190,299**	**-3,712**	**-1.9%**

1/ 2004 reflects $270,000,000 as prior year recoveries rather than additional appropriation as Congress proposed.

2/ 2004 reflects $15 million transferred from the Medical Services appropriation and $15 million transferred from DoD to the DoD VA Health Care Sharing Incentive Fund (HCSIF). 2005 reflects the $15 million for the DoD VA HCSIF in the Medical Services appropriation and the $15 million from DoD in the funding for transfers. In 2006, VA and DoD will each transfer $15 million to this fund after the appropriations bill is signed.

VA is submitting the three-account structure as passed by Congress in 2005 with two minor modifications. First, VA proposes to combine the VHA portion of the three construction accounts into the Medical Facilities appropriation, and second, to realign medical care research support funding from each of the three medical care appropriations to the Medical and Prosthetic Research appropriation.

Although VA is proposing the Medical Care Business Line structure explained in the previous paragraph, we are providing the table below which reflects the three medical care appropriations and the Medical Care Collections Fund (MCCF) in the structure enacted in P.L. 108-447, the Consolidated Appropriations Act, 2005. The purpose of providing this table is to display the resources requested in the President's budget in the Congressionally-enacted structure of the 2005 Appropriations Act. The medical care appropriations are totaled on the table to compare the 2005 to 2006 change in the total direct appropriations traditionally required for the medical care program. In the structure enacted by Congress, VA is requesting $27.8 billion in direct appropriation an increase of $111.3 million, or .4 percent, over the 2005 estimate.

Three Medical Care Appropriations Budget Authority
FY 2005 Enacted Appropriation Structure
(dollars in thousands)

	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)	Percent Change
Appropriation					
Medical services	$19,011,401 1/	$20,000,995	$19,995,141	-$5,854	0.0%
Appn. fr. prop. legisl. fees	0	0	423,996	+423,996	
Subtotal medical services	19,011,401	20,000,995	20,419,137	+418,142	2.1%
Medical administration	4,095,078	4,435,360	4,517,874	+82,514	1.9%
Medical facilities	3,188,817	3,263,040	3,297,669	+34,629	1.1%
Subtotal appropriations	26,295,296	27,699,395	28,234,680	+535,285	1.9%
MCCF collections	1,708,026	1,953,020	2,164,004	+210,984	10.8%
DoD VA HCSIF 2/	30,000	0	0	+0	
Total BA before transfers	**28,033,322**	**29,652,415**	**30,398,684**	+746,269	2.5%
Hurricane supplemental	0	106,932	0	-106,932	-100.0%
Transfers	0	-109,500	0	+109,500	-100.0%
Total budget authority	**$28,033,322**	**$29,649,847**	**$30,398,684**	**+$748,837**	**2.5%**
FTE	**194,272**	**196,876**	**193,139**	**-3,737**	**-1.9%**

1/ 2004 reflects $270,000,000 in appropriation as Congress proposed.
2/ 2004 reflects $15 million transferred from the Medical Services appropriation and $15 million transferred from DoD to the DoD VA Health Care Sharing Incentive Fund (HCSIF). 2005 reflects the $15 million for the DoD VA HCSIF in the Medical Services appropriation and the $15 million from DoD in the funding for transfers. In 2006, VA and DoD will each transfer $15 million to this fund after the appropriations bill is signed.

The Medical Care Business Line resources, for each account combined into the business line, are reflected in the following chart.

Medical Care Business Line 2006 Funding Reconciliation by Subaccount
(dollars in thousands)

	FY 2005 Estimate	FY 2006 Estimate	Increase (+) Decrease (-)
Medical care business line prior appropriation structure			
Medical services	$20,002,905	$19,995,141	-$7,764
Appn. fr. prop. legisl. fees		423,996	+423,996
Subtotal, medical services	20,002,905	20,419,137	+416,232
Medical administration	4,435,830	4,517,874	+82,044
Medical facilities	3,263,744	3,297,669	+33,925
Construction, major (VHA portion)	397,594	539,800	+142,206
Construction, minor (VHA portion)	180,643	160,000	-20,643
Grants for State extended care facilities	104,322	0	-104,322
Subtotal, medical facilities	3,946,303	3,997,469	+51,166
Medical care research support	-384,770	-393,000	-8,230
Homeless transitional housing	-750	-750	+0
DoD VA health care sharing incentive fund 1/	0	0	+0
Subtotal medical care business line appn. before transfers	27,999,518	28,540,730	+541,212
Hurricane supplemental	122,775	0	-122,775
Transfers	-109,500	0	+109,500
Subtotal, medical care business line appropriation	28,012,793	28,540,730	+527,937
Transfer from medical care business line collections			
Transfer from MCCF	1,953,020	2,164,004	+210,984
Subtotal, medical care business line budget authority	29,965,813	30,704,734	+738,921
Reimbursements and prior year recoveries			
Medical services reimbursements	169,000	176,000	+7,000
Medical services prior year recoveries	3,000	3,000	+0
Medical administration reimbursements	25,000	26,000	+1,000
Medical facilities reimbursements	13,000	14,000	+1,000
VA capital asset fund	22,000	0	-22,000
Subtotal, medical facilities	35,000	14,000	-21,000
Subtotal, reimbursements and prior year recoveries	232,000	219,000	-13,000
Adjustments to medical care business line obligations:			
Medical services	223,061	346,129	+123,068
Medical administration	2,864	30,000	+27,136
Medical facilities	-24,518	83,415	+107,933
Construction, major (VHA portion)	27,406	-4,800	-32,206
Construction, minor (VHA portion)	49,414	5,000	-44,414
Grants for State extended care facilities	9,585	12,339	+2,754
VA capital asset fund	-22,000	0	+22,000
Subtotal, medical facilities	39,887	95,954	+56,067
DoD VA health care sharing incentive fund	-13,000	30,000	+43,000
Subtotal, medical care business line adj. to obligations	252,812	502,083	+249,271
Total, medical care business line obligations	**$30,450,625**	**$31,425,817**	**+$975,192**

1/ 2005 reflects the $15 million for the DoD VA HCSIF in the Medical Services appropriation and the $15 million from DoD in the funding for transfers. In 2006, VA and DoD will each transfer $15 million to this fund after the appropriations bill is signed.

Medical Care Business Line Obligations and Financing
(dollars in thousands)

	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Program:				
Provision of veterans health care:				
Acute hospital care	$6,631,521	$7,275,755	$7,622,507	+$346,752
Rehabilitative care	436,469	448,498	458,768	+10,270
Psychiatric care	1,402,625	1,476,370	1,750,473	+274,103
Nursing home care	2,610,265	2,589,101	2,152,813	-436,288
Subacute care	261,776	227,577	198,533	-29,044
Residential care	370,949	407,734	432,641	+24,907
Outpatient care	13,871,707	14,740,550	15,383,202	+642,652
Miscellaneous benefits and services	1,841,352	1,921,597	2,005,381	+83,784
CHAMPVA	471,764	561,636	679,160	+117,524
Construction, major projects	131,736	425,000	535,000	+110,000
Construction, minor projects	202,431	245,900	165,000	-80,900
Grants for State extended care facilities	146,610	113,907	12,339	-101,568
DoD VA Health Care Sharing Inc. Fund	0	17,000	30,000	+13,000
Total obligations	**$28,379,205**	**$30,450,625**	**$31,425,817**	**+$975,192**
Financing:				
Medical care business line	$26,658,686	$28,225,320	$28,116,734	-$108,586
Hurricane supplemental 1/	0	122,775	0	-122,775
Appropriation transfers 2/	15,000	-109,500	0	+109,500
Rescission (P.L. 108-199 and P.L. 108-447)	-160,009	-225,802	0	+225,802
Transfer from MCCF 3/	1,708,026	1,953,020	2,588,000	+634,980
Reimbursements	196,500	229,000	216,000	-13,000
Recovery prior year obligations	340,070	3,000	3,000	+0
Unobligated balance expiring	-22,631	0	0	+0
Unobligated balance available (SOY)	1,261,184	1,617,621	1,364,809	-252,812
Unobligated balance (EOY)	-1,617,621	-1,364,809	-862,726	+502,083
Total resources	**$28,379,205**	**$30,450,625**	**$31,425,817**	**+$975,192**
FTE	**190,744**	**194,011**	**190,299**	**-3,712**

1/ 2005 reflects funding of $122,775,000 from P.L. 108-324, the Military Construction Appropriations and Emergency Hurricane Supplemental Appropriations Act, 2005.

2/ 2004 reflects a transfer of $15,000,000 from DoD to the DoD VA Health Care Sharing Incentive Fund. 2005 reflects the following transfers: $125,000,000 transferred from Medical Services to General Operating Expenses for processing claims; $500,000 from DoD to Medical Services for the Fort Ethan Allen Community Based Outpatient Clinic; $15,000,000 from DoD to the DoD VA Health Care Sharing Incentive Fund.

3/ MCCF includes the following collections that were transferred into the MCCF in P.L. 108-199: long-term care co-payments, Compensation and Pension Living Expenses Program, Parking Program, and Compensated Work Therapy Program.

The transformation in the VA health care system continues. Events such as changes in health care financing, provisions of new services, expansion of community-based outpatient clinics, new collaborative arrangements, and new technologies continue to impact the evolving marketplace. Profound changes have occurred in the health care system and even more change is expected as the Department continues to enhance quality, increase access, improve service satisfaction, and optimize patient functioning. VA's transformation has led to a truly coordinated continuum of care and a system characterized by achievement of performance outcomes to improve services to veterans. VA continues to evolve its national, integrated health care delivery system. The future system will require VA components to function together and in concert with public and private health care facilities, to meet the health care needs of the enrolled population, and to minimize duplication of services. This system will promote efficiency, assure high-quality care, and provide optimal access for the veteran population.

Medical Workload Growth and Quality of Care

Although VA continues to experience growth in the medical system workload, it is growing at a more moderate rate than in past years. The total number of users grew by 64 percent from 1996 to 2003. During this 7-year period, the percentage increase in comparatively higher income veterans (Priority 7-8) far exceeded the growth in the total patient population; the number of priority 7 and 8 patients was 12 times higher in 2003 than it was in 1996. This unprecedented growth led VA to suspend the enrollment of new Priority 8 veterans on January 17, 2003, in order to focus its resources on health care for the Department's core constituents. This budget assumes that VA will continue to suspend the enrollment of new Priority 8 veterans.

VA experienced an annual growth rate of 4.1 percent in 2004 as the number of patients treated increased from 5.0 million in 2003 to 5.2 million in 2004. During 2004, VA treated over 155,000 new patients among VA's highest priority veterans, Priority 1 through 6, and the number of Priority 7 and 8 veterans treated increased by over 13,000.

VA continues to focus its health care system priorities on meeting the needs of our highest priority veterans. The number of patients within this core service population that we project will come to VA for health care in 2006 will be 7.8 percent higher than in 2004. By highlighting our focus on our core constituency, we will continue to produce the desired change in the composition of the veteran population that uses our health care services. During 2006, 71 percent of those using VA's health care system will be veterans with service-connected conditions, those with lower incomes, and veterans with special health care needs. The comparable share in 2004 was 66 percent. In addition, we devote 87 percent of our health care resources to meet the needs of these veterans. Due to their advancing age and multiple medical problems, our highest priority veterans require much

more extensive care that requires significantly more resources, on average, than lower priority veterans. In 2006, VA anticipates treating 3.7 million in this core population, an increase over 2005 of 3 percent, or over 107,000 new patients. As a direct result of the policies proposed in this budget, the Department expects to treat 203,000 (or 16.6 percent) fewer patients in the lower priority groups (Priorities 78) in 2006 as compared to the estimate for 2005.

Unique Patients

Description	2004 Actual	2005 Budget Estimate	2005 Current Estimate	2006 Estimate	Increase (+) Decrease (-)
Priorities 1-6.....	3,422,921	3,660,543	3,583,468	3,690,605	+107,137
Priorities 7-8 1/.....	1,290,662	1,004,340	1,222,738	1,019,461	-203,277
Subtotal Veterans.....	4,713,583	4,664,883	4,806,206	4,710,066	-96,140
Non-Veterans 2/...	453,250	487,073	478,431	491,008	+12,577
Total Unique.....	5,166,833	5,151,956	5,284,637	5,201,074	-83,563

Unique Enrollees

Description	2004 Actual	2005 Budget Estimate	2005 Current Estimate	2006 Estimate	Increase (+) Decrease (-)
Priorities 1-6.....	5,112,310	5,496,178	5,378,879	5,557,704	+178,825
Priorities 7-8 1/.....	2,307,541	1,246,539	2,367,322	1,256,861	-1,110,461
Total Enrollees.....	7,419,851	6,742,717	7,746,201	6,814,565	-931,636

Users as Percent of Enrollees

Description	2004 Actual	2005 Budget Estimate	2005 Current Estimate	2006 Estimate	Increase/ Decrease
Priorities 1-6.....	67.0%	66.6%	66.6%	66.4%	-0.2%
Priorities 7-8 1/.....	55.9%	80.6%	51.7%	81.1%	29.4%
Total Veterans.....	63.5%	69.2%	62.0%	69.1%	7.1%

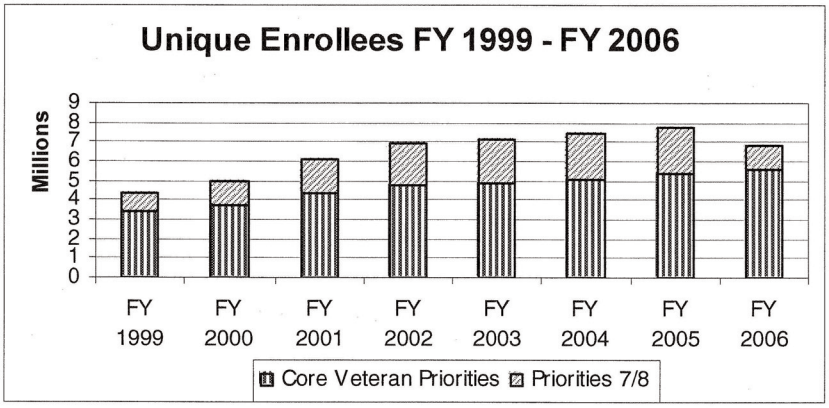
1/ Priority 7 and 8 veterans are higher-income veterans with no service-connected disabilities.
2/ Non-veterans include spousal collateral consultations and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care, and employees receiving preventive occupational immunizations.

To further address the increasing health care workload and to ensure that VA continues to provide timely, high-quality health care to our core population, the budget request includes cost-sharing policy proposals focused primarily on veterans with comparatively higher incomes. These proposals would require lower priority veterans to assume a greater share of the cost of their health care. While veterans with comparatively higher incomes will pay annual enrollment fees and higher pharmacy co-payments, the budget eliminates co-payments for veterans receiving hospice care and for former Prisoners of War. In addition, the

budget includes a provision that allows VA to pay for emergency room care received in non-VA facilities for enrolled veterans.

The history of VA medical service provides insight into whom we treat and why we must propose significant changes in current policies. The modern VA health care system began during World War I with establishment of hospitals to treat and rehabilitate veterans with service-connected disabilities. A second role was added in 1924 with the addition of hospital care for lower-income veterans. Higher-income veterans were added on a resource-available basis in 1986 (with the provision that these veterans pay a portion of their care), and comprised about 2 percent of veteran patients. In 2004, these veterans represented 25 percent of VA's patients and 31 percent of the enrollees. The following chart illustrates the 1999-2006 changes projected in veteran enrollment by these two major priority groupings.

Projected Enrollment
by Patient Priority



Although the overall veteran population is projected to decline over the next 10 years, the demand for VA health care services continues to increase due to the aging of veterans and the comprehensive health care services offered to veterans, including favorable pharmacy benefits; the national reputation of VA as a leader in the delivery of quality health care; long-term care services; and improved access to health care with the opening of additional community-based outpatient clinics. All of these factors have put a severe strain on VA's ability to continue to promptly deliver quality health care, especially for veterans with service-connected conditions, those with lower incomes, and veterans with special needs. The enrollment decision directly addressed this situation and will continue to help ensure that more health care resources are available to meet the needs of its core population, especially those with disabilities that are the result of military service.

VA's appropriation request of $30.7 billion is comprised of five major components. First, VA is proposing a comprehensive set of legislative and regulatory proposals that will continue to focus the VA health care system on care for service-connected disabled veterans as well as veterans with lower incomes and those who have special health care needs. To address the growth in the number of health care users and to ensure that VA continues to provide timely, high-quality health care to our core population, these proposals focus primarily on veterans with comparatively higher incomes. The major components of this set of proposals are described below:

- Assess an annual enrollment fee of $250 for all Priority 7 and 8 veterans. Priority 7 veterans have incomes above $25,843 for a single veteran and below the HUD geographic means test level. Priority 8 veterans are those with incomes above $25,843 for a single veteran and above the HUD geographic means test. The HUD geographic means test is established at a local level such as county.
- Increase a Priority 7 and 8 veteran's share of pharmacy co-payments from $7 to $15 for a 30-day supply of prescriptions paid by veterans who have a greater ability to absorb these co-payments. These two proposals will more closely align VA's co-payments and fees with other public and private plans.
- Focus institutional long-term care services on VA's highest mission priority veterans - those veterans injured or disabled while on active duty, including the veterans returning from Operations Enduring and Iraqi Freedom, those veterans needing short-term care subsequent to a hospital stay, and those veterans requiring hospice or respite care. To ensure fairness and consistency, VA proposes to use these eligibility requirements for VA sponsored long-term care services across all venues – VA, community, and State nursing homes. This long-term care policy will provide the full spectrum of long-term care service to service-connected and catastrophically disabled veterans with special needs, while continuing to provide post-hospitalization care, hospice care, respite care and non-institutional care to all enrolled veterans. Current patients receiving nursing home care will continue to receive care until discharged.

Second, VA is proposing additional legislative or regulatory proposals that are designed to expand or modify health care benefits for the Nation's veterans.

- The emergency care legislative proposal would give VA the authority to pay for insured veteran patients' out-of-pocket expenses for emergency services if their emergency care is obtained outside of the VA health care system. This proposal ensures that all veterans, insured or non-insured, have consistent optimal health care, including care for any emergency condition.
- VA is requesting permanent authority and an annual spending level of up to $130 million for the Homeless Providers Grant and Per Diem Program. Currently, VA is authorized to conduct this program through September 30,

2005, with an annual spending level of $99 million. These additional funds will be used to assist faith-based and community-based organizations to further develop programs and services for homeless veterans.

- VA recommends a legislative proposal that will eliminate the 1998 average daily census (ADC) nursing home capacity requirement which currently requires the staffing and level of extended care services provided by VA every year be the same as the staffing and level of services provided in 1998.
- VA is proposing to exempt co-payment requirements for hospice care provided in any VA setting. Currently, veterans receiving hospice care may be subject to a co-payment, which can vary depending upon the type of VA facility or setting in which the care is given. This proposal would eliminate the co-payment requirement for all hospice care provided in a VA setting so that veterans could equitably receive hospice care in any VA facility.
- VA is proposing to exempt former Prisoners of War (POWs) from co-payments for extended care services. Public Law 108-170, Veterans Health Care, Capital Asset, and Business Improvement Act of 2003, provided VA with the authority to exempt former POWs from the medication co-payment. Former POWs now have no co-payment for hospital and medical services.
- VA is requesting that the maximum payable rate for the Director of Nursing Programs be made comparable to the pay cap for other incumbents of the Senior Executive Service pay system to attract and retain highly skilled nurse executives.
- VA will, under its current regulatory authority, eliminate the current policy of placing veterans' co-payment charges on hold pending payment by insurance companies. Veterans will receive a bill for their co-payment concurrently with VA billing insurance companies for the care. This revised procedure will streamline operations and increase revenue.

Third, VA is requesting additional resources of $975.2 million to care for nearly 5.2 million unique patients. The $975.2 million is comprised of an increase of $117.2 million for appropriation funding, $635 million for collections, and $223 million from reimbursements and utilization of prior year's unobligated funds. VA will deliver community-based health care to the patients who require more health services as they age. VA forecasts an increase in workload and utilization for our core veterans from an actuarial model that projects workload and costing for the enrolled veteran population that will require basic benefits from the VA health care system. The changing health care demands reflect veterans' increasing reliance on pharmaceuticals; the advanced aging of World War II and Korean conflict veterans, many of whom are in greater need of health care; and the outcome of high veteran satisfaction with VA health care delivery. This request also ensures that veterans or servicemembers returning with an injury from Operations Enduring and Iraqi Freedom have timely access to the Department's special health care services; this includes treatment for spinal cord injuries, traumatic brain injuries, post traumatic stress disorder, prosthetics, and rehabilitation of the blind. It also provides funding to care for active-duty servicemembers, Reservists, or National Guard members

who served in a theater of combat operations that are eligible for hospital care, medical services, and nursing home care for injury or illness potentially related to their combat service for a period of 2 years after the members release from the military service.

VA's budget request focuses on the Secretary's priority of providing timely and accessible health care that sets a national standard of excellence for the health care industry. To address this priority, the Department has set a 2006 performance goal of 94 percent for the share of primary care appointments that will be scheduled within 30 days of the desired date. For appointments with specialists, the comparable performance goal is 93 percent.

Fourth, VA is proposing additional management savings of $590 million in 2006 which will partially offset the overall cost of the projected growth in workload and utilization. These efficiencies will be achieved through improved standardization policies in the procurement of supplies, pharmaceuticals, and other capital purchases, as well as in other operational efficiencies such as consolidations.

Fifth, the budget provides capital investment resources of $750 million that are required to restructure the delivery of health care services to the Nation's veterans. Within this level of funding in 2006, VA is aggressively moving forward with major and minor projects identified through the Capital Asset Realignment for Enhanced Services (CARES) process. This request supports the national CARES decision document released by the Secretary in May 2004. The CARES process is the most comprehensive, system-wide approach to, and ongoing process for, identifying the demand for VA care and projecting into the future the appropriate function, size, and location of VA facilities. The CARES plan will ensure that VA is a health care system that balances the need for acute inpatient capacity to meet the needs of aging veteran enrollee population, the growing demands for outpatient services, and rehabilitation needs of special disability populations such as veterans with spinal cord injury, blindness, and traumatic brain injury.

VA's cooperative efforts with DoD continue to improve the health care delivery services to support the President's Management Agenda and Congressional mandates. The departments have improved cooperation in a variety of areas through the VA/DoD Joint Executive Council (JEC) structure. The JEC, co-chaired by the VA Deputy Secretary and the DoD Under Secretary for Personnel and Readiness, sets priorities for the VA/DoD Health Executive Council (HEC) and the VA/DoD Benefits Executive Council (BEC). The JEC implemented a revised Joint Strategic Plan (JSP), which articulates goals for collaboration, establishes priorities for partnering, launches processes to arrive at joint policy decisions and operational guidelines, and institutes performance monitors. The HEC and BEC serve as forums for interagency policy development and senior leader oversight. The Departments identified priority items to improve access to quality health care and reduce the cost of furnishing services.

VA and DoD plan to further institutionalize the VA/DoD partnership by accomplishing the following:

- Accelerating joint capital asset planning;
- Combining separate VA and DoD hi-tech medical equipment contracts and beginning joint purchases;
- Converting DoD's Distribution and Pricing Agreements (DAPA) to VA's Federal Supplies Schedule (FSS) pricing for medical and surgical supplies;
- Continuing work on joint procurements for pharmaceuticals; and
- Ensuring the interoperability between the DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR) to achieve an interoperable, bidirectional medical electronic record based on existing standards.

In 2004, the cooperative efforts between VA and DoD increased the number of joint pharmacy contracts. At the end of 2004, there were 81 joint pharmacy contracts. These two departments continued work on the comprehensive Memorandum of Agreement to combine all the medical and surgical supplies by converting DoD's DAPA to VA's FSS pricing to avoid redundancies. The departments are building a single Federal pricing catalog that will be searchable and available on-line for the department's respective customers. The resultant product is to be released early 2005. At the end of FY 2004, VA and DoD had a total of 14 joint contracts in place. Following review through a competitive process, twelve projects were funded at a cost of $30 million in 2004 through the DoD VA Health Care Sharing Incentive Fund. These projects involve a wide range of services including telemedicine projects, women's health services, a joint cardiac catheterization lab, a joint dialysis unit, and the opening of a joint clinic.

The VA installations by category are provided below.

Medical Care
Number of VA Installations

	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Veterans Integrated Service Networks	21	21	21	+0
VA hospitals 1/	157	157	157	+0
VA nursing homes	134	134	134	+0
Domiciliary residential rehabilitation treat. pgms.	42	42	42	+0
Hospital outpatient clinics	157	157	157	+0
Community-Based Outpatient Clinics (CBOCs)	696	750	778	+28
Independent outpatient clinics	4	4	4	+0
Mobile outpatient clinics	5	5	5	+0
Total outpatient clinics 2/	862	916	944	+28
Veterans Centers	206	206	206	+0

1/ The 2004 number of VA hospitals was reduced from 158 to 157 from the 2004 estimate in the 2005 President's budget submission due to the change in mission of Lakeside, Chicago.
2/ Total outpatient clinics include hospital outpatient clinics, CBOCS, independent outpatient clinics, and mobile outpatient clinics.

Summary of Resource Increases and Decreases

Medical Care Business Line Summary of Resource Increases/Decreases (dollars in thousands)		
Item	FTE	Obligations
I. Program changes for 2006 over 2005 funding:		
1) Projected growth in workload and utilization:		
a.) Veteran increased workload and utilization	0	$409,576
b.) CHAMPVA workload	0	117,524
Subtotal	0	527,100
2) New or expanded initiatives:		
a.) Mental health initiative	627	100,000
b.) Prosthetics initiative	0	100,000
c.) Physician and dentist pay	0	75,488
d.) Homeless Grant and Per Diem Program	0	13,000
Subtotal	627	288,488
3) Proposed policies to focus care on core veterans:		
a.) Assess $250 annual enrollment fee for P 7-8s	0	-206,127
b.) Increase pharmacy co-payments from $7 to $15 for P 7-8s	0	-26,052
c.) Prioritize long-term care for VA/community nursing homes	-4,364	-208,561
Subtotal	-4,364	-440,740
4) Legislative and regulatory proposals		
a.) Emergency care, insured	0	43,145
b.) Amend Homeless Grant and Per Diem Program	0	5,657
c.) Pay adjustment, Director of Nursing Programs	0	37
d.) Long-term care co-payment exempt former POWs	0	-49
e.) Prioritize veterans' care in State nursing homes	0	-293,514
f.) Co-payment for hospice care	0	-5
g.) Eliminate first-party offset	0	30,260
Subtotal	0	-214,469
5) Management efficiencies	0	-590,000
Subtotal	0	-804,469
6) Other medical care business line initiatives:		
a.) Construction for CARES	0	105,720
b.) Grants for State extended care facilities	0	-104,322
c.) Medical realignments (research support)	0	-8,230
d.) DoD VA health care sharing incentive fund	25	13,000
Subtotal	25	6,168
Total program changes	-3,712	-423,453
II. Payroll for existing employees	0	858,924
III. Inflation and rate changes	0	539,721
Total changes	-3,712	$975,192

In 2006, the Medical Care Business Line requires an increase in total resources of $975.2 million. The $975.2 million is comprised of an increase of $117.2 million for appropriation funding, $635 million for collections, and $223 million from reimbursements and utilization of prior year's unobligated balances. These increases are offset by a decrease of $1.7 billion in appropriation from a comprehensive set of legislative, regulatory, and management proposals that will continue our efforts to concentrate the VA health care system resources on our highest priority core veterans – those with service-connected conditions, those with lower incomes, and veterans with special health care needs. The programmatic changes, described below, highlight VA's major 2006 operational requirements.

- Increase of $858.9 million for payroll costs to support full-time equivalent (FTE) employment of 190,299 and an increase of $539.7 million for inflation and rate changes.

- Increase of $409.6 million for increased workload demand and patient utilization of medical services for VA's core veterans. VA will deliver community-based health care to 5.2 million users who require more health services as they age. This increase is derived from an actuarial model that projects workload and costing for the enrolled and user population that will demand benefits from the VA health care system. The utilization projections are based on private sector benchmarks adjusted to reflect the VA health care services package, veteran age, gender, morbidity, reliance on VA versus other health care providers, and degree of health care management. The changing health care demands reflect veterans' increasing reliance on pharmaceuticals; the advanced aging of many World War II and Korean veterans who are in greater need of health care; and the outcome of high veteran satisfaction with VA health care delivery. This initiative also includes an increase of $186.9 million in collections that will result from third-party insurance collections and first-party other co-payments due to increased workload and utilization as well as through improvements in the collections process.

- Increase of $117.5 million for additional CHAMPVA and CHAMPVA for Life claims.

- Increase of $100 million and 627 FTE for VA's mental health initiative to deliver equitable access to care and an integrated system of mental health and substance abuse care that is readily available to veterans across the nation. This request is based on the findings and recommendations of the Veterans Health Administration's (VHA) Mental Health Strategic Plan Workgroup (MHSPW). The MHSPW was guided by the VA Mental Health Task Force to eliminate deficiencies and gaps in the availability and adequacy of mental health services VA provides across the country. The task force identified four major deficiencies and gaps preventing veterans with mental illness and/or substance

abuse from getting the care they need and deserve. These deficiencies and gaps are: variability and gaps in care; reduction of VA substance abuse treatment programs; lack of a national plan for consistent provision of a full complement of care and supportive services, and; lack of involvement and input of mental health leadership into decisions that affect the care of veterans with mental illness. The task force concluded that VA's ability to provide a full continuum of care for veterans with mental disorders is highly variable among Veterans Integrated Service Networks (VISNs) and within VISNs. It also concluded that there are large gaps in the overall availability of ambulatory, inpatient, residential rehabilitation, and long-term care services in some parts of the veterans' health care system. The MHSPW is preparing the first VHA Mental Health Strategic Plan and has taken the charge of the task force and the recommendations of the Action Agenda of the President's New Freedom Commission on Mental Health Care to form the basis of its plan.

- Increase of $100 million for prosthetics for increased workload associated with the purchase and repairs of prosthetics and sensory aids to improve the veterans' quality of life. Over the past 3 years, VA has experienced an average increase of 15 percent in costs of direct patient care related to prosthetics. The number of individual patients VA treats each year has increased from 590,000 in 1998 to 1.4 million in 2004. VA also anticipates additional amputees will enroll in the VA health care system each year as a result of the conflict in Iraq. The prosthetics and sensory aid appliances include all aids, appliances, parts or accessories which are required to replace, support, or substitute for a deformed, weakened, or missing anatomical portion of the body.

- Increase of $75.5 million in additional funding for physician and dentist pay reform enacted in Public Law 108-445 that simplifies and improves pay provisions for physicians and dentists to meet VA's current and long-term strategic needs for market-sensitive and performance-based compensation to retain and recruit the highest quality physicians.

- Increase of $13 million for the Homeless Grant and Per Diem program to provide additional grant funded beds to support homeless veterans.

- Decrease of $440.7 million and 4,364 FTE associated with implementing a comprehensive set of legislative and regulatory proposals designed to concentrate health services on VA's highest priority veterans. These proposals will assess an annual enrollment fee of $250 for Priority 7 and 8 veterans; change Priority 7 and 8 veteran's share of pharmacy co-payments from $7 to $15; and prioritize veterans care in VA and community nursing homes to those veterans injured or disabled while on active duty, including veterans returning from Operations Enduring and Iraqi Freedom, those veterans needing short-term care subsequent to a hospital stay, and those veterans requiring hospice or

respite care. The enrollment fee and increased pharmacy co-payment proposals are estimated to increase collections by $424 million.

- Decrease of $214.5 million for additional legislative or regulatory proposals that are designed to expand or modify health care benefits for the Nation's veterans. These proposals are described below:

    - Provide VA the authority to pay for insured veteran patients' out-of-pocket expenses for emergency services if their emergency care is obtained outside of the VA health care system ($43.1 million).

    - Provide permanent authority and authorize an annual spending level of up to $130 million for the Homeless Providers Grant and Per Diem Program. Currently, VA is authorized to conduct this program through September 30, 2005, with an annual spending level of $99 million. VA is proposing increasing this program from $86 million to $104.7 million, a total increase of $18.7 million. Of the $18.7 million increase, $13 million is from within VA's current spending level of $99 million and an additional $5.7 million increase is required for the legislative proposal ($5.7 million).

    - VA is requesting that the maximum payable rate for the Director of Nursing Programs be made comparable to the pay cap for other incumbents of the Senior Executive Service pay system to attract and retain highly skilled nurse executives ($37,000).

    - Exempt former Prisoners of War (POWs) from co-payments for extended care services (-$49,000 in collections).

    - Prioritize veterans' care in State nursing homes by reimbursing State homes only for care for veterans who meet the following criteria: Priority 1-3 veterans who require short-term and long-term maintenance care; Priority 4-8 veterans who require short-term care; and all priority veterans who require long-term maintenance care for conditions that require specialized care not readily available in the community (such as traumatic brain injury or ventilator dependency) (-$293.5 million).

    - Exempt co-payment requirements for hospice care provided in any VA setting. This proposal would eliminate the co-payment requirement for all hospice care provided in a VA setting so that veterans could equitably receive hospice care in any VA facility (-$5,000 in collections).

- Eliminate, by regulation, the current policy of offsetting veterans' co-payments with collections from insurance companies (+$30.3 million in collections).

- Decrease of $590 million for additional management efficiencies in 2006 that will partially offset the overall cost of the increased workload and utilization. These savings will be achieved through improved standardization policies in the procurement of supplies, pharmaceuticals, and other capital purchases, as well as in other operational efficiencies.

- Increase of $105.7 million for VHA construction for CARES. VA is requesting $699.8 million in direct appropriation for major ($539.8 million) and minor construction projects ($160 million). Additionally, VA is requesting $50 million from the sale of assets and enhanced-use lease proceeds through the CARES process. Of the $50 million, $28 million is from enhanced-use lease proceeds and $22 million is from the sale of assets. The CARES plan will ensure that VA is a health care system that balances the need for growing demands for outpatient services, acute inpatient capacity to meet the needs of aging veteran enrollee population, and rehabilitation needs of special disability populations such as veterans with spinal cord injury, blindness, and traumatic brain injury.

- Decrease of $104.3 million for Grants for State Extended Care Facilities. This decrease is the result of a one-year moratorium in 2006 on VA providing grants to States for construction of extended care facilities. VA intends to complete a review of its long-term care infrastructure, comparing projected demand against capacity. The 2006 budget temporarily halts grants to fund construction of new state extended care facilities to ensure that future construction aligns with the results of this review. The budget also includes a long-term care policy that will provide the full spectrum of long-term care service to service-connected and catastrophically disabled veterans with special needs, while continuing to provide post-hospitalization care, hospice care, respite care and non-institutional care to all enrolled veterans. To ensure consistency, these policies will be adopted throughout VA, community, and state homes.

- Increase of $13 million for the DoD and VA Health Care Sharing Incentives Fund. This initiative provides funding for VA and DoD to establish a joint incentive program to carry out a program to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional, and nationwide levels. VA and DoD are working jointly on twelve projects that involve a wide range of services including telemedicine projects, women's health services, a joint cardiac cathertization lab, a joint dialysis unit, and the opening of a joint clinic.

Workloads and Workload Indicators

The 2006 budget provides for the medical care and treatment of 771,763 inpatients with an average daily census of 47,911 and outpatient medical visits totaling 61.6 million. Workloads and indicators of the medical care and treatment programs are shown in the following tables.

Summary of Workloads for VA and Non-VA facilities

	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Outpatient visits (000):				
Staff	49,966	52,817	55,857	+3,040
Fee	3,779	4,170	4,623	+453
Readjustment counseling	1,031	1,050	1,075	+25
Total	54,776	58,037	61,555	+3,518
Patients Treated:				
Acute hospital care	496,150	508,631	521,966	+13,335
Rehabilitative care	15,280	15,491	15,588	+97
Psychiatric care	110,925	110,925	130,634	+19,709
Nursing home care	93,271	89,961	61,110	-28,851
Subacute care	14,676	13,942	13,384	-558
Residential care	30,217	29,701	29,081	-620
Total inpatient facilities	760,519	768,651	771,763	+3,112
Average Daily Census:				
Acute hospital care	8,591	8,610	8,660	+50
Rehabilitative care	1,215	1,210	1,210	+0
Psychiatric care	4,519	4,519	5,332	+813
Nursing home care	33,984	34,302	21,189	-13,113
Subacute care	488	463	445	-18
Residential care	11,083	11,142	11,075	-67
Total inpatient facilities	59,880	60,246	47,911	-12,335
Home and community-based care	25,523	30,118	35,540	+5,422
Grand Total (inpatient and H&CBC)	85,403	90,364	83,451	-6,913
Length of Stay:				
Acute hospital care	6.3	6.2	6.1	-.1
Rehabilitative care	29.1	28.5	28.3	-.2
Psychiatric care	14.9	14.9	14.9	+0
Nursing home care	133.4	139.2	126.6	-12.6
Subacute care	12.2	12.1	12.1	+0
Residential care	134.2	136.9	139.0	+2.1

Summary of Workloads for VA and Non-VA facilities (continued)				
	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Staff and fee outpatient dental program:				
Staff examinations	530,293	550,000	570,000	+20,000
Staff treatments	158,214	165,000	172,000	+7,000
Fee cases	22,589	29,000	36,000	+7,000
CHAMPVA workloads: 1/				
Inpatient census	210	228	249	+21
Outpatient claims (CHAMPVA/CHAMPVA for Life) (000s)	4,503	5,554	6,659	+1,105

1/ CHAMPVA care for certain dependents and survivors of veterans is provided in both inpatient and outpatient settings.

Employment Analysis *FTE by Activity*				
	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Acute hospital care	51,775	52,172	52,026	-146
Rehabilitative care	4,079	4,203	4,374	+171
Psychiatric care	13,956	13,947	14,576	+629
Nursing home care	22,619	22,349	17,985	-4,364
Subacute care	2,621	2,189	1,829	-360
Residential care	3,550	3,589	3,632	+43
Outpatient care	82,810	86,147	86,445	+298
Miscellaneous benefits and services	8,840	8,800	8,727	-73
CHAMPVA	458	506	571	+65
Construction, major	0	6	6	+0
Construction, minor	36	53	53	+0
DoD VA Health Care Sharing Inc. Fund	0	50	75	+25
Total FTE	190,744	194,011	190,299	-3,712

Capital Investments

In the 2006 President's budget, VA is requesting $750 million for capital investments of which $699.8 million is in direct appropriation and $50 million is from the sale of assets and enhanced-use lease proceeds through the CARES process. Of the $50 million, $28 million is from enhanced-use lease proceeds and $22 million is from the sale of assets. This is an increase of $51.4 million for capital investments over the 2005 estimate. Capital investments consist of major and minor construction projects and grants for construction of State extended care facilities. All construction projects proposed for 2006 have been reviewed through the Capital Asset Realignment for Enhanced Services (CARES) process. In January 2005, VA announced a contract with PricewaterhouseCoopers to complete the studies for 21 sites. CARES is designed to provide greater access to quality care closer to where most veterans live. It allows VA to expand outpatient services and provide more of the care veterans want and use.

Capital Investments 2006 Funding Reconciliation
(dollars in thousands)

	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Capital Investments			
Construction, major (VHA portion)	$397,594	$539,800	+$142,206
Sale of assets/enhanced-use leases	0	50,000	+50,000
Construction, minor (VHA portion)	196,486	160,000	-36,486
Grants for State extended care facilities	104,322	0	-104,322
Subtotal, capital investments appropriation	698,402	749,800	+51,398
Adjustments to capital investments obligations:			
Changes in unobligated balance			
Construction, major (VHA portion)	27,406	-54,800	-82,206
Construction, minor (VHA portion)	49,414	5,000	-44,414
Grants for State extended care facilities	9,585	12,339	+2,754
Subtotal, capital investments adjustments	86,405	-37,461	-123,866
Total, capital investments obligations	**$784,807**	**$712,339**	**-$72,468**

Major and Minor Construction (VHA portion)

The 2006 President's budget request includes $699.8 million in direct appropriation and $50 million from the sale of assets and enhanced-use lease proceeds through the CARES process for major and minor construction, an increase of $155.7 million over the 2005 estimate. Funding for construction provides for constructing, altering, extending, and improving any VA facility. This includes planning, architectural and engineering services, CARES activities, assessments, and site acquisition where the estimated cost of a project is $7,000,000

or over for major construction and less than $7,000,000 for minor construction. P.L. 108-170, raised the minor construction threshold from $4,000,000 to $7,000,000.

Construction 2006 Budgetary Resources
(dollars in thousands)

	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Major Construction Appropriation			
Major projects	$367,743	$534,010	+$166,267
Advance planning fund	13,888	28,290	+14,402
Asbestos abatement	2,976	5,000	+2,024
Claims analyses	992	3,000	+2,008
Facility security	1,985	15,000	+13,015
Hazardous waste abatement	1,984	2,000	+16
Judgment fund	8,026	2,500	-5,526
Subtotal, major construction	397,594	589,800	+192,206
Minor Construction Appropriation			
Minor projects	196,486	160,000	-36,486
Total, construction	**$594,080**	**$749,800**	**+$155,720**

VA is requesting $750 million for the major and minor projects identified through the CARES process. This request supports the national CARES decision document released by the Secretary in May 2004. This budget request is also consistent with the 5-Year Capital Plan published on June 28, 2004, which will be updated for 2006 projects and will be published shortly after the release of the budget. Although several additional follow-up studies are required at approximately 21 sites, this decision document outlines the blueprint for modernizing and restructuring VA's health care system. This effort will require a sustained level of capital investment to restructure the delivery of health care services to the Nation's veterans.

CARES is a comprehensive, system-wide approach to, and ongoing process for, identifying the demand for VA care and projecting into the future the appropriate function, size, and location of VA facilities. The CARES process is the most comprehensive assessment of VA's capital infrastructure and the demand for health care ever achieved. It is based upon sophisticated actuarial models that forecast future demand for veterans' health care, calculate current supply, and identify future gaps in infrastructure capacity. The CARES plan will ensure that VA is a health care system that balances the need for acute inpatient capacity to meet the needs of aging veteran enrollee population, the growing demands for outpatient services, and rehabilitation needs of special disability populations such as veterans with spinal cord injury, blindness, and traumatic brain injury. VA will

establish priorities for individual projects through the normal capital asset planning process, which includes the development of detailed cost data on proposed projects to confirm their cost effectiveness.

VA will open new high-priority Community-Based Outpatient Clinics (CBOCs); realign and consolidate inpatient and outpatient services; expand enhanced-use leases for assisted living and other compatible uses; improve access to inpatient and outpatient care through community contract services; expand, renovate, or replace nursing homes; increase the use of telemedicine to support specialty care needs; and eliminate 3.6 million square feet of vacant space.

A significant amount of new capital funding is required as VA continues to implement aggressively the CARES decisions. In 2006, VA will be consolidating multi-campus hospitals such as in Pittsburgh and Cleveland; designing or constructing new medical care facilities in such places as Las Vegas, Nevada; Anchorage, Alaska; and Biloxi, Mississippi; seismically correcting existing facilities in Long Beach, California, and San Francisco, California; and engaging in other priorities such as correcting patient privacy and designing clinical additions.

The major construction projects for VHA are displayed in the following chart.

Major Projects 1/
(dollars in thousands)

Location	Description	Total Estimated Cost	Available Through 2005	2006 Request	Future Request
Veterans Health Administration (VHA)					
Cleveland, OH	Cleveland-Brecksville Consol.	$102,300	$15,000	$87,300	$0
Pittsburgh, PA	Consolidation of Campuses	185,076	20,000	82,500	82,576
Las Vegas, NV	New Medical Facility	286,000	60,000	199,000	27,000
Gainesville, FL	Correct Patient Privacy	85,200	8,800	76,400	0
Anchorage, AK	OPC & RO	75,270	11,760	63,510	0
Biloxi, MS	Consolidation-Mental Health	174,600	0	17,500	157,100
Fayetteville, AR	Clinical Addition	56,163	0	5,800	50,363
Total, major projects		**$964,609**	**$115,560**	**$532,010** 2/	**$317,039**

1/ The major construction projects listed above were authorized under the scope of Public Law 180-170. This plan was submitted to Congress in June 2004.
2/ Includes resources from the VA Capital Asset Fund of $50 million.

Grants for Construction of State Extended Care Facilities

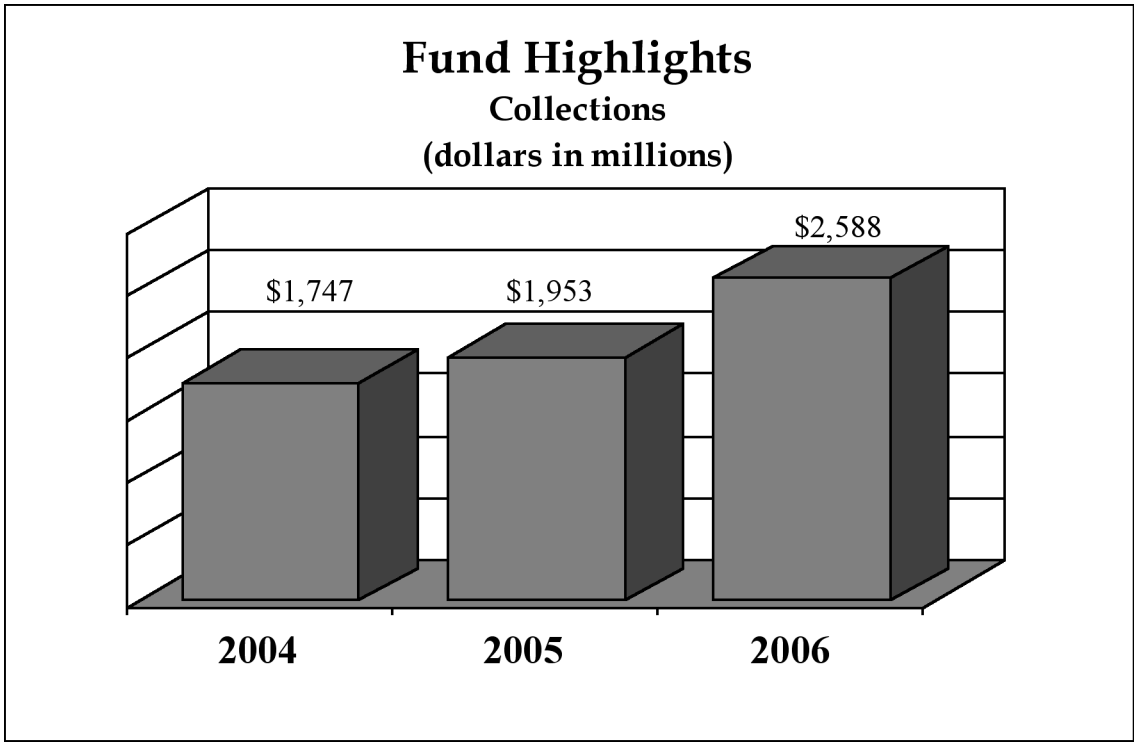
Resources for grants for construction of State extended facilities provides for grants to assist States to acquire or construct State nursing home and domiciliary facilities and to remodel, modify, or alter existing hospital, nursing home, and domiciliary facilities in State homes, for furnishing care to veterans. This program decreases as a result of a one-year moratorium in 2006 on VA providing grants to States for construction of extended care facilities. VA intends to complete a review of its long-term care infrastructure, comparing projected demand against capacity. The 2006 budget temporarily halts grants to fund construction of new state extended care facilities to ensure that future construction aligns with the results of this review. The budget also includes a long-term care policy that will provide the full spectrum of long-term care service to service-connected and catastrophically disabled veterans with special needs, while continuing to provide post-hospitalization care, hospice care, respite care and non-institutional care to all enrolled veterans. To ensure consistency, these policies will be adopted throughout VA, community, and state homes.

Department of Veterans Affairs Capital Asset Fund (CAF)

The CAF provides for costs associated with the transfer and future transfers of real property; enhancing medical care services to veterans by improving patient care facilities through construction projects; and transfer, lease, or adaptive use of a National Register of Historic Places properties. Receipts to this account will be realized from the transfer of real property in accordance with P. L. 108-422. This is a no-year revolving fund. VA is proposing appropriation language under the restructure that will allow these funds to be used under the Medical Facility appropriation for construction purposes.

Medical Care Collections Fund

VA estimates collections of more than $2.5 billion, representing over 8 percent of the available resources in 2006 and an increase of $635 million, a 32.5 percent increase over the 2005 estimate. In 2004, Public Law 108-199, the Consolidated Appropriations Act, 2004, consolidated all collections into the Medical Care Collections Fund (MCCF). This fund now consists of pharmacy co-payments, third-party insurance collections, first-party other co-payments, enhanced use revenue, long-term care co-payments (formerly Veterans Extended Care Revolving Fund), Compensated Work Therapy Program (formerly Special Therapeutics Rehabilitation and Activities Fund), Parking Program (formerly Parking Revolving Fund), and Compensation and Pension Living Expenses Program (formerly Medical Facilities Revolving Fund). The objective of consolidating all collections into the MCCF is to improve planning, simplify systems, enhance the recovery of funds, and focus on accountability for medical collections.



Medical Care Collections Summary of Fund Activity (dollars in thousands)				
	2004 1/ Actual	2005 Estimate	2006 2/ Estimate	Increase (+) Decrease (-)
Pharmacy co-payments	$623,215	$722,370	773,000	+$50,630
Third-party insurance collections	960,176	1,018,380	1,175,625	+157,245
First-party other co-payments	113,878	131,450	136,052	+4,602
Eliminate first-party offset	0	0	30,260	+30,260
Enhanced use revenue	459	28,625	625	-28,000
Long-term care co-payments	5,077	6,600	500	-6,100
Compensated work therapy collections	40,488	41,440	43,764	+2,324
Parking fees	3,349	3,500	3,500	+0
Compensation & pension living expenses	634	655	678	+23
Subtotal	1,747,276	1,953,020	2,164,004	+210,984
Proposed legislation, user fees				
Increase pharmacy co-payment for P 7/8s	0	0	176,278	+176,278
Assess $250 enrollment fee	0	0	247,718	+247,718
Subtotal proposed legislation, user fees	0	0	423,996	+423,996
Total collections	**$1,747,276**	**$1,953,020**	**$2,588,000**	**+$634,980**

1/ Pharmacy co-payments, third-party insurance collections, first-party other co-payments, and enhanced use revenue collections. These numbers reflect collections of $1,697,725,529 received by VA in 2004. Due to the difference in the timing from when the funds are received and transferred into the medical care account, other charts reflect $1,658,488,140 transferred to the medical care account in 2004. The remainder of the funds collected in 2004 will be transferred in 2005.

2/ Reflects collections from proposed policies; the collections will be subject to PAYGO and will be available to the extent provided in the appropriations act.

Medical Care Collections Fund

Public Law 105-33, the Balanced Budget Act of 1997, established the Department of Veteran Affairs Medical Care Collections Fund (MCCF) and requires that amounts collected or recovered after June 30, 1997, be deposited in this fund. VA has the authority to collect inpatient, outpatient, medication, and nursing home co-payments; authority for certain income verification; authority to recover third-party insurance payments from veterans for non-service connected conditions; and authority to collect revenue from enhanced use leases. Public Law 108-7, the Consolidated Appropriations Resolution, 2003, granted permanent authority to recover pharmacy co-payments for outpatient medication. VA's authority to do income verification with the Social Security Administration and Internal Revenue Service was extended through September 30, 2008, by section 402(d) of Public Law 106-419, the Veterans Benefits and Health Care Improvement Act of 2000. Public Law 107-135, Department of Veterans Affairs Health Care Programs

Enhancement Act of 2001, extended the authority to recover third party insurance payments from service-connected veterans for nonservice-connected conditions through October 1, 2007.

Improving Collection in the Future

- With the establishment of the VHA Chief Business Office (CBO) an expanded revenue improvement strategy has been formulated that combines the 2001 Revenue Improvement Plan with a series of additional tactical and strategic objectives targeting a combination of immediate, mid-term, and long-term improvements to the broad range of business processes encompassing VA revenue activities. Following guidance articulated in the President's Management Agenda, the Chief Business Office has pursued its current revenue improvement strategy by modeling industry best performance. To that outcome, the strategies now being pursued include establishment of industry based performance and operational metrics, development of technology enhancements, and integration of industry proven business approaches including the establishment of centralized revenue operation centers.

- Accurate insurance information is critical for VHA to maintain and exceed its current levels of recoveries. The past few years have seen a dramatic decline in inpatient days of care provided and a large increase in the number of outpatient clinic visits. This shift translates into lower revenues for inpatient services and higher revenue for outpatient care. VHA has mandated that all facilities establish patient pre-registration, to include the use of software that assists in gathering and updating the patient insurance information files.

- VA is working with the Centers for Medicare/Medicaid Services (CMS) contractors for the purpose of providing VA with a Medicare-equivalent remittance advice (MRA) for veterans who are using VA services and are covered by Medicare. These MRAs will reflect the deductible and coinsurance amounts that Medicare supplemental insurers will use to reimburse VA for health care services VA provided to veterans for their non-service connected treatment. Improved revenue collections by VA are the expected outcomes of providing remittance notices along with VA claims to health plans that provide coverage secondary to Medicare.

- Leveraging the health care industry's migration to national standard electronic data exchanges under the Health Insurance Portability and Accountability Act (HIPAA), the following initiatives are underway to add efficiencies to the billing and collections processes.

- The electronic Insurance Identification and Verification (e-IIV) project is providing VA medical centers (VAMCs) with an automated mechanism to obtain veterans' insurance information from health plans that participate in the electronic data exchange. VA is pursuing enhancements to e-IIV which will provide additional insurance information stored by other government agencies (Internal Revenue Service; Centers for Medicare and Medicaid Services; and Social Security Administration).

- The electronic Payments or Third Party Electronic Data Interchange Lockbox (e-Payments) initiative was implemented in October 2003. e-Payments enables the receipt and posting of third party electronic payments and remittance advices from health plans against third party health care claims. The software will continue to be enhanced to allow more efficient processing of electric payments and useful reporting. Complete benefits of the software will not be realized until all payers fully transition to HIPAA capability.

- Enhancements to existing electronic Claims (e-Claims) software are being implemented in VA to incorporate new requirements of the HIPAA Electronic Transactions and Code Sets Final Rule.

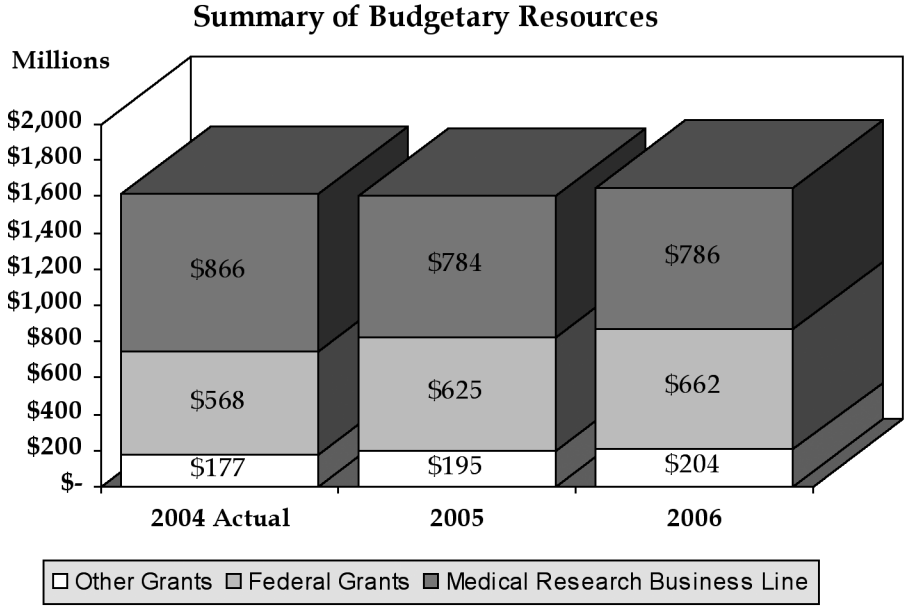
- The e-Pharmacy Claims software is currently being tested. The addition of this functionality in the VistA system provides electronic outpatient pharmacy claims processing. This enhancement provides real time claims adjudication for outpatient pharmacy claims.

- The VA is currently working on a congressionally directed pilot project which involves the replacement of the VistA Billing and Accounts Receivable software products with commercial-off-the-shelf (COTS) patient management, billing, and accounts receivable software. The Patient Financial Services System (PFSS) pilot encompasses both the integration of the COTS software into the VistA clinical environment and the introduction of improved business processes. The PFSS project is scheduled to be piloted in VISN 10 at the Cleveland VA Medical Center in the fall of 2005. The objectives of the PFSS pilot include the following:
    - increasing the accuracy of bills and documentation;
    - reducing operating costs,
    - complying with VA and Centers for Medicare and Medicaid Services (CMS) policies;
    - generating additional revenue;
    - reducing outstanding accounts receivable;
    - increasing accuracy of bills to and payments received from insurance carriers; and
    - enhancing data capture and integrity, and decreasing time to bill.

Medical and Prosthetic Research Business Line

The Medical and Prosthetic Research Business Line appropriation is comprised of both the Medical and Prosthetic Research and the Medical Care Research Support accounts. The Medical and Prosthetic Research account is an intramural program, whose mission is to advance medical knowledge and create innovations to advance the health and care of veterans and the nation. It supports research that facilitates and improves the primary function of VHA, which is to provide high quality and cost-effective medical care to eligible veterans and contribute to the Nation's knowledge on disease and disability. This appropriation provides funds for the conduct of the VA's Medical, Rehabilitation, Health Services, and Cooperative Studies research programs. The Medical and Prosthetic Research appropriation request of $786.0 million supports 48 percent of the research effort, with the balance coming from other Federal appropriations as well as private sources. It is expected that non-VA funding will increase in 2006.

Medical Care Research Support, previously paid from the Medical Care appropriation, contributes funding towards the indirect cost of the VA Research and Development program and is estimated to be $393.0 million in 2006. This includes: facility costs of heat, light, telephone and other utilities associated with laboratory space; administrative cost of human resource support, fiscal service, and supply service attributable to research; research's portion of a medical center's hazardous waste disposal and nuclear medicine licenses; and, most importantly, the time clinicians devote to their research activities. Over 72 percent of VA investigators are clinicians, who provide direct patient care to veterans in addition to performing research. This activity will now be reflected in the Medical Research Business Line.



Overall, VA is projecting a $49.2 million increase in total research resources of $1.7 billion, a 3 percent increase. For direct appropriation, VA is requesting $786.0 million, which is a 0.2 percent increase over the 2005 level, and $47.2 million in grant funding. The $49.2 million increase is due to an increase of $47.2 million for non-VA grant funding from federal and private research programs and an increase of $2 million in direct appropriation funding. VA will realign its research funding to focus on those programs that are most important to the health care of veterans. The following table summarizes the budgetary resources for the Medical and Prosthetic Research Business Line activities. In addition to receiving direct support for VA initiated research from appropriated funds, VA clinician/investigators compete for and obtain funding from other Federal and non-Federal sources. Their success is a direct reflection of the high caliber of VA's corps of researchers who are able to work in an environment conducive to research. In addition to outside funding, the Medical and Prosthetic Research program receives support from the Medical Care appropriation, which funds laboratory facilities and ancillary support services and pays a portion of clinician/investigators' salaries.

Summary of Resources

(dollars in thousands)

	2004 Actual	2005 Estimate	2006 Estimate	Increase(+) Decrease(-)
Medical Research Business Line	$866,427	$784,040	786,000	+$1,960
Federal Grants	568,318	624,800	662,288	+37,488
Other Grants (voluntary agencies)	177,344	194,700	204,435	+9,735
Total	$1,612,089	$1,603,540	$1,652,723	+$49,183

Veteran health issues are addressed comprehensively in the four program divisions as follows:

Bio-medical Laboratory Science Research and Development Service– Bio-medical Laboratory Science Research will encompass all basic science and pre-clinical research, including but not limited to anatomy, biochemistry, biophysics, microbiology, virology, neuroscience, engineering, materials science, pharmacology, physiology, genetics, molecular biology, and animal models of human diseases.

Clinical Science Research and Development Service – Clinical Science Research will encompass interventional and observational studies in humans, including but not limited to pharmacological and surgical studies. Single subject, pilot studies, feasibility trials and cooperative studies will all be funded and managed by the Clinical Research Service.

Health Services Research and Development Service – Health Services Research will manage and fund research related to population studies, health economics, quality of care, and epidemiology. Translational studies for applying best practices will also be an important continuing role for HSR&D.

Rehabilitation Research and Development Service – Rehabilitation Research and Development will fund and manage all research related to chronic disabling conditions in veterans, including but not limited to nervous system diseases and injury, limb loss, rehabilitation engineering, and chronic medical conditions. Studies of rehabilitation treatment efficacy, rehabilitation outcomes, and ascertaining the impact of rehabilitation strategies on Cure and Care will be a fundamental component of the RR&D portfolio.

In 2006, the research program will continue its strong support of projects originated in prior years. In addition, it will continue its strong commitment and increased emphasis on Designated Research Areas (DRAs) highly relevant to the health care needs of veterans.

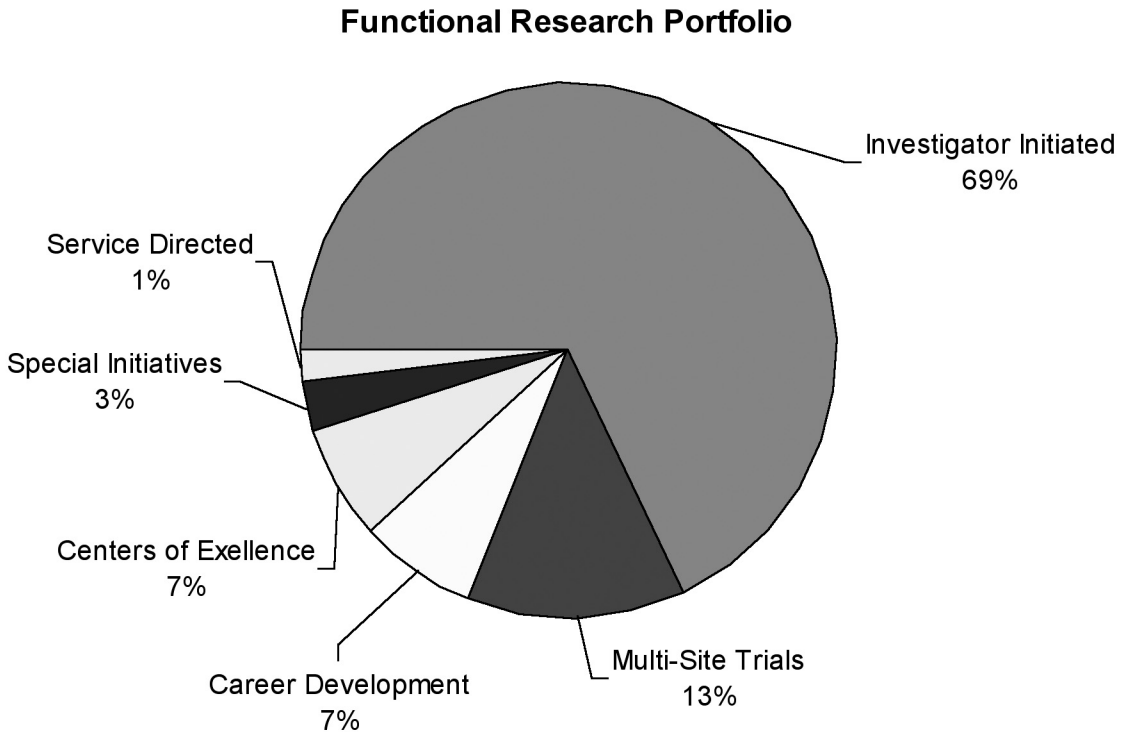
Obligations, Budget Authority, and Employment
(dollars in thousands)

	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Medical Research Business Line				
Obligations	$897,129	$852,767	$849,044	-$3,723
Average employment (FTE):				
Direct	6,538	5,941	5,671	-270
Reimbursable	260	260	260	+0
Total	6,798	6,201	5,931	-270
Appropriation	$868,834	$790,363	$786,000	-$4,363
Rescission (Research)	-2,407	-3,245	0	+3,245
Rescission (Support)	0	-3,078	0	+3,078
Total	$866,427	$784,040	$786,000	+$1,960
Outlays:				
Obligations	$897,129	$852,767	$849,044	-$3,723
Obligated balance, start of year	122,537	123,875	132,780	+8,905
Obligated balance, end of year	-123,875	-132,780	-155,062	-22,282
Reimbursements	-43,176	-50,000	-50,000	+0
Adjustments in accounts	-2,245	0	0	+0
Total Outlays (net)	$850,370	$793,862	$776,762	-$17,100

For the Medical and Prosthetic Research Business Line, a total of $786.0 million and 5,931 FTE will provide 48 percent of the $1.7 billion total research funding and support over 2,655 high-priority research projects focused in Designated Research Areas (DRAs). The number of projects is expected to decrease by 62 from the 2005 level. The other funding comes from other federal and private medical research

organizations such as the Department of Defense and National Institute of Health. This level of funding will allow the research program to maintain research centers in the areas of Gulf War illnesses, diabetes, heart disease, chronic viral diseases (e.g., HIV/AIDS), Parkinson's disease, spinal cord injury, prostate cancer, depression, environmental hazards, and women's issues, as well as rehabilitation and Health Services Research and Development (HSR&D) field programs. VA will continue to seek to increase non-appropriated research funding from the private and public sectors. The 2006 request will maintain the research effort directed towards improving veterans health and care.

The Functional Research Portfolio pie chart that follows shows the distribution of VA's research among five different types of investigative approaches. The investigator-initiated research and multi-site trials portion of the portfolio make up 82 percent of the entire program. This is indicative of the openness of the system to new ideas.



Projects by Designated Research Areas				
	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Designated Research Areas:				
Aging	606	538	503	-35
Cancer	182	162	151	-11
Infectious Diseases	96	85	80	-5
Kidney Diseases	76	68	63	-5
Diabetes and Major Complications	78	69	65	-4
Lung Disorders	95	84	79	-5
Heart Diseases	185	164	154	-10
Other Chronic Diseases	339	301	282	-19
Mental Illness	175	156	146	-10
Substance Abuse	162	144	135	-9
Sensory Loss	79	70	66	-4
Acute and Traumatic Injury	331	294	275	-19
Health Systems	205	182	170	-12
Special Populations	98	87	81	-6
Military Occupations & Environmental Exposures	176	157	146	-11
Emerging Pathogens/Bio-Terrorism	23	21	19	-2
Digestive Diseases	112	99	93	-6

The Designated Research Areas (DRA) listed above represent areas of particular importance to our veteran population. Because of the multiplicative nature of research, many individual research projects have a bearing on more than one DRA. For example, heart disease relates both to chronic disease and aging. This research helps us perform our mission "to discover knowledge and create innovations that advance the health and care of veterans and the nation."

Canteen Service Revolving Fund

Current revenues finance this revolving fund and provide for the maintenance and operation of the Veterans Canteen Service at all VA hospitals and domiciliaries. The canteens provide reasonably priced merchandise and services to comfort veterans in hospitals, nursing homes, and domiciliaries.

Fund Highlights
(dollars in thousands)

	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Obligations	$248,732	$250,857	$254,032	+$3,175
Revenue	$239,529	$242,690	$245,710	+$3,020
Expense (-)	-$237,713	-$241,689	-$244,600	-$2,911
Net operating income	$1,816	$1,001	$1,110	+$109
Non-operating income (+) or loss (-)	-$426	$100	$150	+$50
Net income	$1,390	$1,101	$1,260	+$159
Outlays (net)	$3,447	$1,820	$496	-$1,324
Average employment	2,890	2,900	2,900	+0

Medical Center Research Organizations

Veterans' Benefits and Services Act of 1988 (Public Law 100-322) authorized "VA Research and Education Corporations" to be created at Department of Veterans Affiars medical centers. This program has been known as the "Medical Center Research Organizations" after Congress expanded the Non-profit Research Corporations authority to include education (Public Law 106-117). This public law authorizes Department of Veterans Affairs' medical center nonprofit organizations to provide a flexible funding mechanism for the conduct of research. These organizations derive funds to operate various research activities from Federal and non-Federal sources. This fund is self-sustaining and requires no appropriation to support these activities.

Fund Highlights
(dollars in thousands)

	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Contributions	$185,231	$184,279	$183,145	-$1,134
Obligations (expenses)	$178,768	$180,631	$179,814	-$817

General Post Fund, National Homes

This trust fund is used to promote the comfort and welfare of veterans in hospitals and homes where no general appropriation is available. The fund consists of gifts, bequests, and proceeds from the sale of property left in the care of VA facilities by former beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Donations from pharmaceutical companies, nonprofit corporations and individuals to support VA medical research can also be deposited into this fund.

No appropriation funding is being requested for the transitional housing loan program for 2006 because no loan activity on this program has occurred since its inception in September 1994. Although there were numerous inquiries about the program and requests for application materials, to date only one complete application has been received (which was disapproved due to the financial status of the organization and planned use of loan proceeds).

Obligations and Budget Authority
(dollars in thousands)

	2004 Actual	2005 Estimate	2006 Estimate	Increase (+) Decrease (-)
Program:				
Obligations	$28,213	$30,821	$32,451	+$1,630
Budget authority (permanent, indefinite)	$31,066	$30,719	$32,255	+$1,536